CASE MANAGEMENT QUARTERLY REVIEW (T2022)

Case Manager must complete form quarterly, with input from appropriate members of the IPC team.

Participant Name: _____ SSN#: _____ Plan Start Date: _____ Quarterly Review Date: _____

Case Manager Name: _____ NPI #: _____ Waiver: Adult _____ Child _____ ABI_____

Case Management Organization Name: _____ NPI #:

RESTRAINT & RESTRICTION DATA REPORTING (Only for those Participants who have a Positive Behavior Support Plan with Restraints and/or Restrictions)

Data on restraint usage and restrictive interventions must be faxed to the Division within 30 days of the quarterly review. *Please fax only this page of the quarterly review to 307-777-6047 if restraints and/or restrictions are due to positive behavior support plan .*

3 MONTHS	# of RESTRAINTS		# of RESTRICTIONS (numbers only)			
Month/Year	**Mechanical**	**Physical**	**Possessions** *(money, food, items)*	**Privacy**	**Communication** *(phone, mail, visitors)*	**Community Access**
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Emergency Restraint used *(Type and Date)*: _____ **Follow up:** _____

An Emergency Restraint shall be reported to DDD as a critical incident after July 1, 2009 but does not have to be reported to all other agencies unless directed by DDD. Emergency restraint shall only be used once. ***If it is anticipated that another restraint may be needed, a Positive Behavior Support Plan must be developed and the restraint added to the Participant's Rights Restrictions. See Chapter 45, Section 28.***

BEHAVIORAL CONCERNS

Number of **internal** incidents reports: _____ Number of **DDD reportable critical** incidents: _____

Incident trends and/or concerns this quarter needing follow-up: None needed ☐

The providers' IR policies determine the criteria of a reportable internal incident. The CM is responsible for monitoring the plan of care implementation after incidents to see if protocols, positive behavior support plan, and/or supports and supervision were appropriately provided or need follow up. Does the participant need medical follow up? Does the plan need to be changed? Do providers need to be retrained?

_____

Behavior trends, changes in type/frequency, and/or concerns this quarter needing follow-up: None needed ☐

The CM shall check data on IRs and service documentation notes to see if behaviors are increasing, decreasing, changing, etc. Does the behavior plan need modified? Is it being implemented properly? Do staff need to be retrained? Is the supervision level being met? Does supervision need to be changed?

_____

PRN Usage trends or concerns with Behavior Modifying Medication(s): None needed ☐

The CM shall review documentation of PRN usage for participants who receive assistance from providers with medications. The CM shall ensure that a qualified person analyzes the patterns of PRN usage, continually assesses, monitors and re-evaluates the participant to determine if the PRN medication is still needed or is still appropriate for the participant's medical condition. The CM shall review documentation of IRs pertaining to PRN usage and the follow up performed by the provider to ensure the plan of care was implemented correctly and follow up on any concerns identified.

_____

OTHER HEALTH AND SAFETY CONCERNS

Any potentially significant **risks** identified through documentation over the past quarter? Yes ☐ No ☐

Changes in the **medication regimen** or medical protocols? Yes ☐ No ☐

Did any medical assessments, blood tests, or medical visits occur last quarter to monitor the participant's health due to medications, injuries, surgeries, or other diagnosed conditions? Yes ☐ No ☐

Concerns identified or follow up needed due to PRN usage, not related to the PBS plan? Yes ☐ No ☐

Any significant **health** changes over the past quarter? Yes ☐ No ☐

Unplanned changes in **diet**, and/or significant changes in **weight** gain or loss? Yes ☐ No ☐

Case Manager Signature: _____ Date:_____

CASE MANAGEMENT QUARTERLY REVIEW (T2022)

Case Manager must complete form quarterly, with input from appropriate members of the IPC team.

Any significant **seizure** changes (frequency/duration)? Yes ☐ No ☐ N/A ☐

Changes in adaptive **equipment** needs or in the condition of equipment? Yes ☐ No ☐ N/A ☐

If YES to any of the above changes, list specifics and follow-up actions being taken to evaluate and address changes and/or revise the plan of care:

_____

PARTICIPANT SATISFACTION *(all waivers)*

Provider	Service	Satisfaction *Level 1-5:	How Are Things Going With This Provider? (Summarize)	Concerns Needing Follow-up

*Levels: 0 – Refused, 1 – Very Dissatisfied, 2 –Dissatisfied, 3 –Neutral, 4 –Satisfied, 5 - Very Satisfied

Other Comments: _____

For participants 18 years of age or older

Participant Interview *(if unable to communicate, interview the guardian)*

1. What do you do in the community? _____
   a. How often? _____
   b. What would you change? _____
2. If you are working, what do you like about your job? _____
   a. What don't you like or what would you want to change? _____
3. If you are not working, do you want to work? Yes ☐ No ☐
   a. If YES, what is the team doing to support you in getting a job? *(List specific actions.)* _____
4. What do you like about where you live? _____
   a. What don't you like? _____
5. What else would you like your providers to help you with? ☐ None
   a. Supports _____
   b. Activities _____
   c. Personal Relationships _____
   d. Other _____

Follow-up Required from Interview: _____

Follow-up actions still pending from last quarterly review:

_____

Follow-up actions needed for next quarterly review:

_____

Case Manager Signature: _____ Date: _____